HHS Region IV Tribal Consultation

Executive Summary

The 2011 Tribal Consultation for Region IV took place March 30, 2011, in Cherokee, North Carolina. The purpose of the consultation was to allow Tribal leaders to discuss programmatic issues and overall concerns of Tribes at the local level with U.S. Department of Health and Human Services (HHS) officials. The regional session also provided an opportunity for Tribes to hear updates from HHS, discuss the updated HHS Tribal Consultation Policy, provide testimony and/or comments on topics of interest, and pose questions on issues that concern Tribal communities and members.

Vickie Bradley, Health and Medical Director for the Eastern Band of Cherokee Indians, served as Tribal moderator. The HHS moderator was Anton Gunn, Director of the Region IV Office of HHS. Following an opening prayer and traditional dancing, Mr. Gunn opened the Region IV Tribal Consultation. Mr. Gunn next introduced Lauren Kidwell, Deputy Director of the Office of Intergovernmental Affairs at HHS. Providing an update from the national level, Ms. Kidwell noted that 2010 proved a significant year with the passing of the Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA).

During the next session, Mr. Gunn invited the heads of various HHS Operating Divisions to share quarterly reports or updates. Session participants heard comments from such departments as the Administration for Children and Families (ACF), the Administration on Aging (AoA), the Health Resources and Services Administration (HRSA) and the Centers for Medicare and Medicaid Services (CMS). Major topics of discussion included the shortage of emergency room staff in Indian Country, Tribal input at State Health Officers' meetings and cuts to Centers for Disease Control and Prevention (CDC)'s REACH program, which focuses on eliminating racial and ethnic health disparities.

The afternoon session included panel discussions on three cross-cutting issues that touch several divisions of HHS.

The first panel addressed the ACA. Panelist Lauren Kidwell discussed health insurance exchanges, a marketplace for consumers to shop for affordable private insurance in the public sphere. States have until 2014 to get their exchanges up and running, she said. In order to receive the next round of Federal funding to launch their exchanges, states must develop a detailed plan for how they will consult with Tribes.

The number of people who will be eligible for Medicaid will increase by 2014, which should benefit Tribal communities, said panelist Renard Murray of CMS. People earning an income of up to 133 percent of the federal poverty level—which translates to an income of $29,000 for a family of four—would be eligible for Medicaid. That will increase Medicare rolls by 16 million people, he said.

Regarding the insurance exchange, Mr. Casey Cooper of the Eastern Band of Cherokee Indians said he wanted to go on record with three main points: the issue of an essential community provider, Section 206, and the definition of Indian.

An Essential Community Provider (ECP) is a primary care system that provides for a high proportion of medically underserved and indigent populations. There is no question that anybody providing primary care in Indian Country meets the definition of ECP, he said. CMS should just issue a statement that Tribal providers and the Indian Health Service (IHS) meet the definition so there is no question or debate.

Section 206 of the IHCIA clearly states that IHS and Tribal providers have the right to bill as though they are in network, regardless of whether they are in network or not, with private insurance, said Mr. Cooper. The challenge comes when insurers choose for the IHS or the Tribal provider to be out of network, and then they issue payment to the beneficiary, he said. Section 206 should help Tribes overcome that problem.

With regard to the definition of Indian, Indian Country supports the CMS definition of Indian, said Mr. Cooper. He hopes that will be the definition used in the interpretation and the application of the provisions of the law.

Mr. Cooper also asked for more information on billing the Department of Veterans Affairs. Cherokee serves as the medical home and provides primary care to about 800 veterans, he said. He couldn't understand why the Tribe can't get the address and demographic information needed to send a claim to the VA to which that veteran is assigned. Ms. Martha Ketcher of IHS said the functional mechanisms to process claims/reimbursements by the VA and the Department of Defense have not been formulated. Mr. Cooper said issues such as payer of last result put the Tribes in an unfortunate quandary.

Mr. Gunn said he would figure out how to begin a conversation with the VA about that issue. Meeting participants requested greater cooperation between all the agencies and departments connected to the IHCIA, especially given the one-year anniversary of the Act's implementation.

The second panel included staff from the ACF, AoA, HRSA, CMS, and IHS.

Mr. Murray of CMS noted a preventive services brochure that Medicare patients can use during medical visits. The brochure highlights a checklist of services that Medicare covers for free. Further, Medicare beneficiaries can track the services they receive at https://mymedicare.gov/.

Michael Toedt of Cherokee Indian Hospital reported a crisis of going several months without any behavioral health services for elders, adults or children. He asked about funding opportunities for mental health providers or behavioral health services. He also would like to expand geriatric services. Because a representative from the Substance Abuse and Mental Health Services Administration (SAMHSA) didn't attend the meeting, Mr. Gunn pledged to get answers back to Mr. Toedt.

Ms. Ketcher gave an update on suicide prevention efforts. She passed along suggestions she gained from a recent listening session, such as developing parenting classes, expanding gatekeeper training at the area and community levels, conducting mental health education awareness, and increasing involvement of youth.

Ms. Ketcher also led a late afternoon PowerPoint presentation on IHS. The agency has been negotiating renewing funding agreements, including multi-year agreements. IHS also has held listening sessions so Tribal leaders can conference about the new law. Departments such as CMS, the Internal Revenue Service (IRS) and the Office of Personnel Management (OPM) have participated in those sessions, she said.

IHS has taken a lead on implementing the IHCIA, she reported. The agency is working with established timelines, and Tribes have asked IHS to address certain issues to further implement provisions of the Act. Ms. Ketcher also discussed the Federal Employees Health Benefits (FEHB) Program, electronic health records/meaningful use and budget updates.

During the question-and-answer portion of this session, Mr. Cooper reiterated concerns about the annual IHS budget. He compared the per capita funding for health care of American Indians to veterans, Medicare/Medicaid beneficiaries and Federal employees. Funding is obviously disparate, he said, which puts the IHS in a difficult situation. He called for the full funding of the IHS.

The Tribal priorities cited during the consultation include the following:

1. Mr. Gunn will look for ways to encourage a conversation with the Department of Veterans Affairs regarding how the Tribes submit claims to the VA as well as issues surrounding payer of last resort. Tribes seek a greater sense of cooperation with the VA, Department of Defense and all agencies and departments connected to the Indian Health Care Improvement Act.
2. HHS staff will inform Tribes of State Health Officers' meetings so Tribal representatives can attend regularly.
3. Mr. Gunn will share information about the CDC Tribal Consultation.
4. Improve population wellness by investing in children's health with preventative health services and continuing to address such major concerns as diabetes, depression and substance abuse.
5. Increase emergency room staffing in Indian Country.
6. Maintain vigilant focus on racial and ethnic health disparities through the CDC's REACH program and other efforts.
7. Secure funding for mental health providers, behavioral health services and the expansion of geriatric services.

In wrapping up the day's events, Mr. Gunn made a commitment to sharing information about the CDC Tribal Consultation session and relaying Tribal concerns back to appropriate leaders within HHS. He also stressed the importance of continued focus on health disparities in Indian Country. Further, Region IV Tribes should begin receiving information about State Health Officers meetings, said Mr. Gunn. He also noted that another quarterly regional call would take place in June.